MAINE ASSOCIATION OF HEALTH PLANS

Understanding the Perspective of Private Data Submitters: Ideas for Improving Efficiency and Lowering Costs

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Who we are:

- Aetna
- Anthem Blue Cross and Blue Shield
- CIGNA
- Harvard Pilgrim Health Care
- UnitedHealth Group

- Our members collectively provide health insurance coverage to over 90% of privately insured Maine people.

Health Plans and APCDs: The National Context

- Nine states have existing APCDs
- Five more are in the process of implementing APCDs

- MeAHP plans participate in all of these efforts, although not all in each one.

- Health insurers in particular, are uniquely positioned to drive large-scale reform toward a high-quality, knowledge-based health care delivery system. Each of the MeAHP members has developed transparency tools for its membership.

Critical issues for data submitters

- Harmonization of data submission standards across states is crucial.
- Data submissions from carriers should be limited to those elements utilized by carriers for the payment of claims.
- The best sources and access points for health data need to be sought.
- Carriers can only pass through only what providers submit. They should not be required to interpret, correct or enhance provider submitted fields.
- Health plans need a way to verify the accuracy of their own data in APCD outputs.

Costs and Limitations of Claims Data

- Operational costs
  - Estimate of $10,000 to program a single change to a single data element, and there are thousands across multiple platforms
- Assessment costs
  - Assessments are paid annually by insurers and providers to support the MHDO

Limitations of Claims Data

- There are systemic limitations to claims data in terms of both accuracy and timing that need to be acknowledged and understood.
  - Claims information cannot be provided in real time like clinical data from EMRs or HIN. Only 50% of claims are adjudicated within one month of service provided, additional 35% in second month. The current release schedule of 90 days after close of quarter already requires monthly submissions from carriers.
  - Claims data does not include outcomes information such as labs or radiology results.
  - There is a lack of precision in cost estimates derived from claims data.
  - NPI issues – NPI not available for all servicing providers on claims, NPI “confusion” between individual practitioners and billing practices, inaccurate NPIs on claims. Carriers may not need an NPI number to process a claim. Therefore, submitters should only be required to pass through the NPI submitted on the claim.

Submissions Process Improvements

- Sequential load processes are problematic
  - Submitters need comprehensive, clear messaging about what fields are causing problems and why
  - Minimizing or reducing delays and unnecessary communications will enable multiple issues to be addressed simultaneously and more quickly, increasing efficiency and lowering costs for all parties.
  - Expedite the data submission process by identifying all the issues with a data file at once. Upon submission, carriers should quickly receive one report back detailing **all** the errors or problems with their data files.
  - Where automated error messages frequently generate questions, messages should be revised to better explain the error.

Thresholds

- Triage or prioritize data elements so everyone's focus is on the most critical elements.

- Formalize process around setting and changing thresholds.
  - Submitter input
  - Predictable annual schedule
  - Adequate notice

- Create options for annual or longer period waivers to save time and expense for all parties.
  - Example: ancillary coverage

Thresholds Continued…

- Experiment with new approaches such as advance applications for threshold adjustments
- Maintain better files/records on why and when waivers or adjustments were granted
- Continue to seek opportunities to address common problems across submitters with centralized solutions such as current provider linkage